

USAWC STRATEGY RESEARCH PROJECT

TRANSFORMATION OF THE MILITARY HEALTH SYSTEM

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This SRP is submitted in partial fulfillment of the requirements of the Master of Strategic Studies Degree. The U.S. Army War College is accredited by the Commission on Higher Education of the Middle States Association of Colleges and Schools, 3624 Market Street, Philadelphia, PA 19104, (215) 662-5606. The Commission on Higher Education is an institutional accrediting agency recognized by the U.S. Secretary of Education and the Council for Higher Education Accreditation.

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Report Documentation Page				Form Approved OMB No. 0704-0188	
Public reporting burden for the collection of information is estimated to average 1 hour per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to Washington Headquarters Services, Directorate for Information Operations and Reports, 1215 Jefferson Davis Highway, Suite 1204, Arlington VA 22202-4302. Respondents should be aware that notwithstanding any other provision of law, no person shall be subject to a penalty for failing to comply with a collection of information if it does not display a currently valid OMB control number.					
1. REPORT DATE 15 MAR 2006		2. REPORT TYPE		3. DATES COVERED	
4. TITLE AND SUBTITLE Transformation of the Military Health System				5a. CONTRACT NUMBER	
				5b. GRANT NUMBER	
				5c. PROGRAM ELEMENT NUMBER	
6. AUTHOR(S) Kelvin Owens				5d. PROJECT NUMBER	
				5e. TASK NUMBER	
				5f. WORK UNIT NUMBER	
7. PERFORMING ORGANIZATION NAME(S) AND ADDRESS(ES) U.S. Army War College, Carlisle Barracks, Carlisle, PA, 17013-5050				8. PERFORMING ORGANIZATION REPORT NUMBER	
9. SPONSORING/MONITORING AGENCY NAME(S) AND ADDRESS(ES)				10. SPONSOR/MONITOR'S ACRONYM(S)	
				11. SPONSOR/MONITOR'S REPORT NUMBER(S)	
12. DISTRIBUTION/AVAILABILITY STATEMENT Approved for public release; distribution unlimited.					
13. SUPPLEMENTARY NOTES					
14. ABSTRACT See Attached.					
15. SUBJECT TERMS					
16. SECURITY CLASSIFICATION OF:			17. LIMITATION OF ABSTRACT	18. NUMBER OF PAGES 20	19a. NAME OF RESPONSIBLE PERSON
a. REPORT unclassified	b. ABSTRACT unclassified	c. THIS PAGE unclassified			

ABSTRACT

AUTHOR: Colonel Kelvin B. Owens
TITLE: Transformation of the Military Health System
FORMAT: Strategy Research Project
DATE: 27 January 2006 WORD COUNT: 5,012 PAGES: 20
KEY TERMS: Military Health System, Joint Medical Command
CLASSIFICATION: Unclassified

The Department of Defense Military Health System dates back to 1775 when it supported the Continental Army. The purpose of the Military Health System (MHS) is to provide medical care (preventive and resuscitative care) for our Soldiers, Sailors, Airmen, and Marines, who may be deployed in operations such as Operation Enduring Freedom and Operation Iraqi Freedom or assigned around the world in support of our national interests. MHS beneficiaries have grown to a population of over nine million. MHS delivers medical care in over eighty hospitals and more than five hundred medical clinics throughout the world, making it one of the largest medical infrastructures of this great nation. In the MHS organizational structure, each Service Component has a Surgeon General and a separate medical command structure and the Department of Defense oversees medical support via the Assistant Secretary of Defense for Health Affairs. Given the President's emphasis on transforming the way the Department of Defense runs, should the Department of Defense now establish a Joint Medical Command or a Unified Medical Command? If so, should this Joint Medical Command operate at the strategic, operational, and tactical levels?

TRANSFORMATION OF THE MILITARY HEALTH SYSTEM

The U.S. National Security Strategy (NSS) states that the Department of Defense must be innovative in supporting warfare in the 21st Century. Accordingly, the NSS advocates joint operations and exploits advances in intelligence capabilities. It also directs the Department of Defense (DoD) to transform the way it operates, especially in the areas of financial management and recruitment and retention of personnel.¹ The U.S. National Defense Strategy (NDS) also identifies continuous transformation as one of its implementation guidelines and directs that transformation is not limited to deployable forces, but to the entire DoD, which includes the Military Health System (MHS).² This system has served this great nation since 1775, when the Continental Congress established the medical service in support of a 20,000 man army.³ It has evolved into three separate Service Medical Organizations supporting the Army, Navy, and Air Force in order to provide required medical support as close to the action as possible.⁴ Though the DoD has made some changes in its structure and is implementing transformation initiatives to meet the 2002 National Security Strategy goals, transformation efforts do not support a Joint or Unified Military Health System.⁵ Indeed the MHS continues to harbor redundancies, and limit flexibility. This strategic research project argues for the need to transform the existing MHS into a Joint Medical Command for the 21st Century. It reviews current DoD transformation initiatives and the current structure of the MHS. Finally, it recommends changes for the future to reduce redundancy, to improve management, and to provide flexibility in support of a joint force in the 21st Century. The magnitude of this problem is evident in the size and complexity of the organization the MHS serves:

The DoD is perhaps the largest and most complex organization in the world. It manages more than twice the budget of the world's largest corporation, employs more people than the population of a third of the world's countries, provides medical care for as many patients as the largest health management organization, and carries five hundred times the number of inventory items as the world's largest commercial retail operation... This mission, however, also demands that the Department be as nimble, adaptive, flexible, and accountable as any organization in the world.⁶

The Chairman of the Joint Chiefs of Staff published the U.S. National Military Strategy (NMS) to provide guidance for the Joint Force in achieving the goals of the NSS/NDS.⁷ The NMS identifies transformation as its third priority and informs the Service Chiefs that transformation requires cultural adjustments, innovation, and creativity as some of the keys for achieving transformation.⁸ The NMS further states while "deploying and sustaining military capabilities," DoD must continue transforming the force. Thus DoD must remain committed to

sustainment, force generation requirements, and other capabilities. Further, deploying a joint force requires DoD to have the capability to recruit, train, and retain personnel as well as to plan, program, acquire, and sustain required equipment and facilities to maintain readiness.⁹ Though transformation is not new to the DoD, it has taken on new urgency since the publication of the NSS.

Prior to the publication of the NDS and NMS, DoD conducted modernization initiatives in segments. Each Department or Service evaluated and improved their business processes, information technology systems, or other systems in order to enhance their ability to provide support to the warfighter and defeat the nation's enemies. For example, the Defense Logistics Agency (DLA), implemented Business Systems Modernization in an effort to incorporate proven commercial business practices to enhance DLA's ability to support the warfighter. DLA also implemented Medical Regional Standardization -- a proven technique used by commercial vendors to reduce medical logistics costs and the number of stocked lines of inventory and to improve materiel standardization and product availability for patient care. These improvements paved the way for group purchasing initiatives, which in turn improved patient care. The Army Medical Department -- specifically, the United States Army Medical Materiel Agency -- implemented Business Systems Modernization initiatives to improve systems support and integration with one of their major suppliers, DLA. These initiatives saved millions of dollars and improved support to the warfighter, but they only affected a small segment of the DoD. Since these initiatives, DoD has sought to transform the force in an effort to improve support to the joint force and capitalize on proven commercial business practices that can be incorporated into the DoD. Therefore, Secretary of Defense Rumsfeld, shortly before September 11, published the Quadrennial Defense Review Report (QDR) and identified transformation of the DoD as a key element for survival in the 21st Century.¹⁰ The QDR identifies "strengthening joint operations through standing joint task force headquarters, improved joint command and control, joint training, and an expanded joint forces presence policy" as one of its four transformation pillars.¹¹

In an effort to transform the DoD and incorporate proven business practices that enhance the way DoD is run, the Deputy Secretary of Defense, under the direction of the Secretary of Defense, published the DoD Enterprise Transition Plan Volume I: Defense Business Transformation Overview.¹² The Enterprise Transition Plan (ETP) established four priorities for improving support to the joint warfighter: support the joint war fighting capability of the DoD, enable rapid access to information for strategic decisions, reduce the cost of defense business operations, and improve financial stewardship to the American people.¹³

The ETP and its business transformation program relies on the strengths of the Services and Defense Agencies which have their own way of conducting business, gaining appropriations, and processing information.¹⁴ The ETP focuses on six DoD Components in order to achieve DoD transformation: the Army, Navy, Air Force, U.S. Transportation Command, the Defense Logistics Agency (DLA), and the Defense Finance and Accounting Service.¹⁵ Each component is directed to develop their transformation plan in accordance with the guidelines contained within this document and under the watchful eye of the Deputy Secretary of Defense, who is responsible for overseeing business transformation along with members of the Defense Business Systems Management Committee. These overseers represent senior leadership of the Military Departments, Defense Agencies, Combatant Commands, and the DoD Chief Information Office.¹⁶

Along with the six components, DoD identified five Core Business Missions that cross all Departments and Service Components.¹⁷ These Core Business Missions (CBMs) establish standard business transformation priorities, eliminate redundant systems, and facilitate evaluation of investment decisions. CBMs also provide a framework for the DoD to integrate business systems and eliminate stovepipes, focusing on: Human Resources Management, Weapon System Lifecycle Management, Materiel Supply & Service Management, Real Property & Installations Lifecycle Management, and Financial Management.¹⁸ These CBMs are essential for transforming the DoD, but they concentrate mainly on enhancing and integrating information technology systems among Defense Agencies, Services, and Combatant Commands, enabling them to provide timely information to DoD leadership at all levels as well as to standardize business processes with commercial vendors and manufacturers.¹⁹ The CBMs enable each Service Component or Defense Agency to develop integrated systems. However, the ETP does not identify the MHS as a component for this initiative.

Secretary of Defense Rumsfeld and his senior staff members rejected the Joint Chiefs recommendation for a joint medical command or an agency to control military medical costs.²⁰ Secretary Chu stated that the large budget in medical care and operations is managed by a staff, instead of a command and further distributed to the three separate services for execution.²¹ In charge of an organization that provides support to over nine million people, that expends over \$20 billion annually, and that is one of the largest healthcare organizations in the world; the DoD can no longer ignore the need to transform the MHS.²² The MHS consists of the Assistant Secretary of Defense for Health Affairs, the TRICARE Management Activity, the Service Component Surgeons General, the Service Component medical personnel, and the 81 hospitals and 514 clinics throughout the world.²³ The relationships of these organizations are

shown below in figure 1. Each of these included organizations has its own reporting or command structure and has a specific function within the MHS. But the ultimate MHS goal is to care for the personnel of the armed forces.

Organizational Relationships

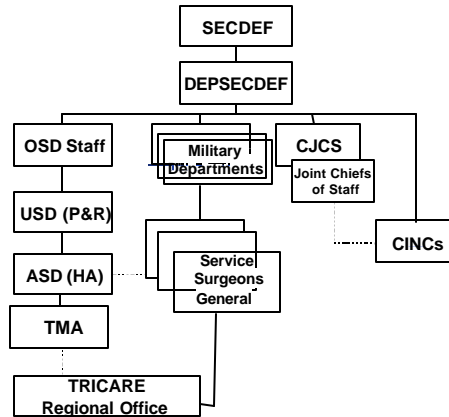


FIGURE 1, ORGANIZATIONAL RELATIONSHIPS²⁴

The Assistant Secretary of Defense for Health Affairs (ASD[HA]) is the principal staff assistant and advisor for all aspects of the DoD health program to the Under Secretary of Defense for Personnel and Readiness, the Secretary, and Deputy Secretary of Defense. Some of the ASD(HA)'s responsibilities include medical readiness of the armed forces, medical support to the armed services including their dependents, and supervision of the operation of fixed medical facilities, along with personnel, programs, planning, programming, and budgeting for all aspects of the medical resources and activities located throughout the DoD.²⁵ However, the awesome responsibility is somewhat limited to the fixed facilities and the personnel that are assigned to those facilities. The ASD(HA) does not have the authority to make changes within the chain of command of a Military Department, nor can he assign or reassign military personnel to different commands or organizations. Also, he or she is not responsible for the recruiting and retention of military medical personnel for the Military Departments.

The ASD(HA) works closely with the DoD Comptroller, Chairman of the Joint Chiefs, Combatant Commanders, Secretaries, and Surgeons General of the Military Departments to ensure that their medical requirements are incorporated in the medical unified program and

budget.²⁶ To carry out these responsibilities, the ASD(HA) relies heavily on the Military Departments in implementing changes or enforcing policies. For example, the ASD(HA) published a memorandum implementing the Joint Patient Tracking Application which is a web based tool used to track patients as they move through the medical treatment and evacuation system from point of injury to a definitive care facility.²⁷ Though a great initiative, it met with resistance from the Central Command Air Force Surgeon Staff during Operation Iraqi Freedom 04-06; this command directed subordinates to use another tool (the Global Expeditionary Medical System) instead of the Joint Patient Tracking Application as specified by ASD(HA) memorandum.²⁸ This resistance caused some problems during Operation Iraqi Freedom 04-06 because subordinate commands which had implemented ASD(HA) guidance were required to use two systems. This added requirement resulted in additional workload and double entry of the same information into the systems. The ASD(HA) has published numerous policies, memorandums, and directives that have provided guidance for the MHS. This guidance ranges from the hiring of contract personnel, specialty pay for medical and dental officers, joint formularies, establishment of working groups and committees, and a host of other topics all intended to provide the best medical care possible to its customers, the American Armed Forces Personnel.²⁹

These policies are often developed, implemented, and executed through the TRICARE Management Activity (TMA). This TMA was established by consolidating the TRICARE Support Office, the Defense Medical Program Activity, and the integration of other offices under the ASD(HA) in order to enhance the performance of TRICARE worldwide.³⁰ The TMA reports directly to the ASD(HA) and is responsible for executing ASD(HA) policies, TRICARE health and medical/dental resources, the Defense Health Program, the DoD Unified Medical Program accounts, contracts for managed care support, and other health programs. TMA oversees the four TRICARE Regional Offices: West, North, South, and Overseas.³¹ TRICARE Regional Offices provide guidance and oversight for their specific geographic regions; they are staffed by members of the Military Departments.³²

The Secretaries of the Military Departments are responsible for staffing and operating the TRICARE Regional Offices (TRO) designated by the ASD(HA).³³ TRO's are headed by a senior military officer designated as a Lead Agent responsible for the MHS within an assigned geographical area. Lead Agents are under the operational control of his Military Department, but are also responsible to the Director, TRICARE Management Activity, in the management and execution of the MHS policies and the uniform health benefit. The TRO's not only have a Lead Agent but also a Lead Agent Director who manages the day-to-day operation of the TRO's

and coordinates with the Medical Treatment Facility Commanders for the delivery of healthcare within the geographical region.³⁴ Military Departments are largely responsible for the operation of the TRO's, while the ASD(HA) is responsible for training medical personnel and the financial resources needed to operate and man fixed military treatment facilities. Normally, the Lead Agent rotates each year among the Services within each geographical area. This ensures that each Service has an opportunity to lead the TRO and ensures joint responsibility within the region.

The Military Departments (Service Components) all have Surgeons General on their Special Staff. They are responsible for the overall management of their respective health service systems and for validating requirements, recruiting, training, and retention of medical personnel. They also develop policies and regulate health service support, medical standards for personnel, and a myriad of other responsibilities. The Surgeons General play an important role in advising their Service Secretaries and Senior Military Officers on the health of the force. They also play a key role in assisting the ASD(HA) and the TRICARE Management Activity in the performance of their duties.

Under the TRICARE Management Activity (TMA) Charter, numerous committees have been established to ensure representation from all Services and representation of the ASD(HA) and TMA from all the Departments as they develop policies, requirements, or procedures in support of the MHS mission. For example, the TRICARE Executive Committee is the senior committee for oversight and evaluation responsibilities to ensure that the MHS is prepared to support the continuum of military operations. TRICARE Executive Committee membership include representatives of the Surgeons General of the Army, Navy, Air Force, and the Principal Deputy Assistant Secretary for Health Affairs.³⁵ Committees such as the Defense Medical Readiness Training and Education Council review areas such as the joint medical training requirements, training for interoperability, and consolidating training requirements and facilities in order to reduce redundancies. This work has played an invaluable role in enhancing the MHS. Overall, there are at least fifty-six committees or working groups identified under the TMA Charter. These committees are comprised of Senior Officers (often flag officers) from the Service Medical Departments and the ASD(HA).³⁶ Has the time come to transform these organizations and establish a strategic-level Joint Medical Command that is responsible for the entire Military Health System?

Consolidating the DoD Medical leadership in ASD(HA), TMA, the Surgeons General, and the TRO's at the strategic or national level would streamline the MHS, provide a true single source for development and execution of policies, procedures, programs, requirements, and

provide a focal point for the Secretary of Defense, Congressional Leadership, and Service Components for MHS issues. As the MHS is presently structured, ASD(HA), TMA, and the Surgeons General provide redundant and disunified senior leadership. This situation can be alleviated by the development of a Joint or Unified Medical Command that is solely responsible for the MHS - to include the recruitment, retention, training, and management of medical facilities and personnel. For example, the Army Medical Department currently serves as the Executive Agent for veterinary support to the DoD and is responsible for the recruitment, retention, training, and assignment of veterinary personnel who support the entire DoD by overseeing food inspections, care of DoD working dogs, and other DoD veterinary requirements.³⁷

Since the DoD is in the midst of transformation and is reviewing current business practices and organizations that provide required support to its customer base, the MHS must review agencies or organizations that provide the same support to its customer base - for example, Kaiser Permanente. Kaiser Permanente is one of the largest health care organizations in the United States; it provides medical care for over eight million people in nine states. It employs over 147,000 personnel and physicians. With an annual operating budget of over \$25.3 billion, Kaiser Permanente doctors perform 430,000 surgeries, deliver 90,000 infants, and perform 32,000 outpatient procedures. Kaiser Permanente pharmacists fill over nine million prescriptions annually.^{38/39} Kaiser Permanente operates an organization almost as large as the MHS, but does so from a single office that provides direction, facilities, compliance, human resources administration, policy, legal support, quality assurance, leadership, government relations, and more. It has managed to remain an effective organization since 1945.⁴⁰ But critics will claim that the MHS is not a business and deploys military personnel around the world. Even so, Kaiser Permanente seems to have broken the code in centrally managing a multi-billion dollar organization from a central office, unlike the MHS. DoD must review how Kaiser Permanente operates and incorporate their business practices. Kaiser Permanent has the ability to focus not only at the strategic level in their coordination with Congress, the American Medical Society, and other organizations both nationally and internationally in obtaining funds, legal assistance, and legislation in order to provide top cover for their organization while ensuring compliance with their policies as they provide medical care to their customers.⁴¹

Another organization that has demonstrated successful central management of its resources (though not a medical organization) is the Defense Logistics Agency (DLA). Located in Virginia, DLA is the DoD's largest combat support agency. It provides logistics support to the

DoD, through nine Field Activities, located in forty-eight states and twenty-eight countries. DLA has over twenty-two thousand civilian and military employees; it has been compared to a "Fortune 500" Company.⁴² Again, centralized control with decentralized execution. Some of the responsibilities of DLA include budget planning and execution, controlling costs, personnel management, policy development and implementation, and supporting the soldier in the field. The lineage of DLA can be traced back to World War II.⁴³ If Congress inquires about why something was purchased, contracted for, or some other issue, Congress goes to DLA, not the Services, when DLA purchased the item for the Service. But the current MHS structure cannot respond to Congressional demands like an organization like DLA. For example, the Surgeons General as well as the ASD(HA) have been called to testify or appear before of a Congressional hearing to explain what a particular Service Component is doing in relation to health care as evident by Lieutenant General Taylor and Vice Admiral Arthur have testified in front of Congressional Representatives on the DoD Health Program.⁴⁴ The ASD(HA) has on numerous occasions been required to appear before Congress to address MHS issues.⁴⁵ With a single point of contact and elimination or integration of levels, the DoD can reduce manpower requirements, eliminate redundancy, and improve accountability and support to Congress and the warfighter.

Figure 1 shows that the Service Surgeons General report directly to their respective Service Chiefs, but have only an administrative relationship with the ASD(HA).⁴⁶ In order to improve operation of the MHS, these relationships must be transformed so that the Secretary of Defense has command authority over the MHS. A Joint Medical Command under the command and control of the Secretary of Defense satisfies this requirement but requires an amendment to Title 10, United States Code and a Presidential decision to establish a Joint Medical Command or a Unified Medical Command similar to the Special Operations Command.⁴⁷ The Service Surgeons General retain their responsibility for advising their respective Secretary and Chief on the medical readiness of their force, but the Joint Medical Command will serve as the Unified Medical Command supporting the Combatant Commanders with Title 10, United States Code (USC) responsibility.

Under Title 10, USC each Service Component is required to: man, equip, train, recruit, organize, and supply their respective service.⁴⁸ Realigned under a Joint Medical or Unified Medical Command, MHS would be responsible for providing medical care for all of DoD; MHS would then operate with enhanced authority and flexibility. No longer will the ASD(HA) be required to submit the Defense Health Program Budget to the Services to execute medical care and training, except for Service unique requirements. But the Joint Medical or Unified Medical

Command, under the direction and supervision of the ASD(HA), will have complete control of the management of the budget, to include making necessary administrative adjustments to support critical shortfalls in another region. Currently, the ASD(HA) lacks the authority to recruit, train, retain, assign (Human Resource Management functions), and provide supplies and equipment for the MHS. These functions are presently executed under the Military Departments.

MHS personnel undergo the same education and training -- regardless of Service Component -- in relation to their medical skills. Most schools, Medical and Dental Schools for example, are accredited by an academic accreditation association and require the individual to obtain a license prior to practicing medicine.⁴⁹ The Defense Base Closure and Realignment Commission recommended that Joint Training Centers be established.⁵⁰ These requirements ensure that medical personnel receive standardized, quality training and elimination of redundancies. The Joint Medical Command can easily assume the functions of recruiting, training, assigning, and retaining medical personnel by maintaining medical personnel that are currently serving in recruiting, training, and human resource organizations. For example, Recruiters are responsible for obtaining qualified personnel to enter military service. They recruit people who desire to serve in a particular service for a specific specialty. Any recruit that desires to serve in a medical specialty for a specific Service, such as the Navy for example, undergoes, basic Naval training and then attends a Joint Medical Training Course commonly referred to Advanced Individual Training for their respective medical specialty.

Once training is complete, the Seaman is assigned to a subordinate medical command that supports a Navy or Marine organization. The Seaman becomes indoctrinated into the Navy operational requirements, but provides medical support under the direction of the Joint Medical Command. If a dentist or a doctor desires to enter military service and concentrate his service on Army operations, the candidate attends the Basic Officers Course, where he learns basic infantry skills and then attends the Joint Medical Command Basic Course -- Phase II at Fort Sam Houston, Texas. Following completion of Phase II, he is assigned to an Army organization and provides support to Army Forces during his military career. Medical training continues under the guidance of the Joint Medical Command for all medical personnel. Therefore, training and continuing education requirements remain under the direction and supervision of the ASD(HA). As previously mentioned, the Joint Medical Command should resemble a Unified Combatant Command.

At the Operational level, Combatant Commands are assigned geographic or functional responsibility by the President of the United States and are responsible for all assigned forces

within their area of responsibility.⁵¹ There are nine Combatant Commands. One of them, the U.S. Special Operations Command, exemplifies the manner in which a Joint Medical Command should operate. The U. S. Special Operations Command (USSOCOM) is responsible for developing strategy, doctrine, budget proposals, expenditures, specialized courses, validating and establishing priorities, combat readiness, promotions, assignments, retention, professional development, and the acquisition of specialized materiel, supplies, and services in support of assigned personnel.⁵² According to the 2005 Special Operations Command Annual Report, Honorable Thomas W. O'Connell is the Assistant Secretary of Defense for Special Operations and Low Intensity Conflict and is "the principal staff assistant and civilian advisor to the Under Secretary of Defense for Policy (USD[P]) and the Secretary of Defense on Special Operations and Low Intensity Conflict matters."⁵³ In this role, he oversees USSOCOM and is the civilian leader for the command. Under the Joint Medical Command (JMC) concept, the ASD(HA) has similar responsibilities and can be aligned in the same manner similar to USSOCOM. Therefore, the ASD(HA) should retain his current role and assume the civilian leadership role of the JMC.

USSOCOM provides Special Operations Component Commands to geographical Combatant Commanders in support of their assigned mission. For example, Central Command has the Special Operations Command Central assigned to it.⁵⁴ The Special Operations Command Central is responsible for assigned forces and supports the Combatant Commander in the execution of his assigned missions.⁵⁵ A Combatant Command should have a subordinate Joint Medical or Medical Component Command (see figure 2) assigned in order to command and control medical forces within a geographic region.

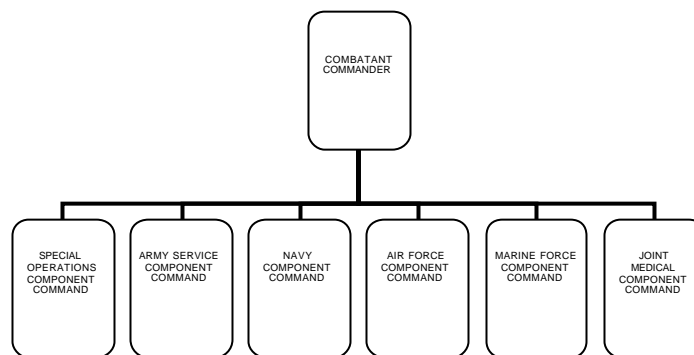


FIGURE 2, SAMPLE COMBATANT COMMAND WITH JMCC

This concept further enhances the ability of the Combatant Commander to ensure medical readiness and support to the forces and all DoD beneficiaries during the full spectrum of operations. A Joint Medical Component Command provides a single source for the Combatant Commander on all aspects of medical support to the region, allows centralized development and enforcement of policies that enhances support, coordination, and execution. If a Joint Medical Component Command was operating during Operation Iraqi Freedom 04-06 (OIF), issues such as redundancy in medical support, disjointed implementation of medical technology, and the difficulty to move medical personnel and equipment would not have been an issue. The Joint Medical Component Command (JMCC) like other Component Commands would be responsible for the training, readiness, assignment, and execution of medical support to the region. This concept can also be implemented at the tactical level.

At the operational and tactical level, a central command element would be able to employ the required medical structure needed to support any operation. During OIF 04-06, the Air Force employed Expeditionary Medical Support (EMEDS) in support of its personnel and the Army employed medical organizations to support their units. With the exception of the 332d Air Transportable Hospital, none of the EMEDS were under command or administrative authority of the Task Force 44th Medical Command (TF 44), the echelon above Division command and control medical element. The result of this caused a redundancy of medical personnel and capability located at a couple of locations within the theater of operations. This redundancy could have been alleviated if TF 44 had the authority to control the EMEDS elements operating in the theater. For example, surgical capabilities could have been enhanced at other locations and clinical specialties could have been put to better use if all the medical elements operating within the Multi-National Corps – Iraq area of responsibility (AOR) were under the command and control of TF 44. Implementation of medical information technology would not have been hindered; in fact, implementation of the Theater Medical Information Program would have gone a lot smoother in capturing medical care provided to the deployed force and in providing the commanders with near real time information on the status of their wounded personnel. Rotation of specialties such as neurosurgeons would not have been an issue if a Joint Medical Command were established in order to eliminate a request for assistance from other Service Components to provide support or take on specific rotations in support of OIF. A JMC increases flexibility and unity of effort which is required at all levels of operations.

In conclusion, the Joint Medical Command is the future for medical support in the 21st Century; however, achieving this goal requires transformation of the current structure instead of the “incremental” or “patchwork” changes that the MHS has normally executed. Secretary of

Defense Rumsfeld in the National Defense Strategy of the United States of America identified “natural forces of inertia and resistance to change...” as an area of vulnerability in transforming the force.⁵⁶ His assessment is right on target and this “inertia” must be overcome by the forceful elimination of parochialism that often comes about when people are afraid of change. “Organizational reforms are rife with unintended consequences. ... the core precept has been to do no harm.”⁵⁷ An example of this inadequacy is the response provided to the Chairman, Defense Base Closure and Realignment Commission’s question on establishing a Joint Medical Command in which the Medical Joint Cross-Service Group said that “... that consideration of a Joint Medical Command, with its complex command and control ramifications, was outside the scope of their charter.”⁵⁸ Sometimes you have to go outside the box or charter in order to make something better. Unfortunately, this kind of mentality is one of the shortcomings of our military profession in that we tend to stay inside of the box or charter in order to achieve the mission at hand. The only way to enhance medical interoperability, management of the MHS, and increase flexibility is to transform the MHS which requires the support and unfortunate “push” by the President, Congress, and the Secretary of Defense.

Transformation as defined in the Transformation Planning Guidance is “a process that shapes the changing nature of military competition and cooperation through new combinations of concepts, capabilities, people, and organizations ...”⁵⁹ The ASD(HA) recently announced the establishment of the Military Health System Office of Transformation.⁶⁰ This office is responsible for transforming the MHS and will consist of representatives from the Office of the Secretary of Defense, the Services, and the TMA with the focus of building a military health system for the 21st Century that provides high standard medical care during peacetime and war.⁶¹ Jim Collins, a prominent business analyst, stated that of the eleven companies that they evaluated, ten of them that evolved from good to great companies had Chief Executive Officers that came from within their organization.⁶² Hopefully, the individuals selected to be in the Military Health System Office of Transformation take the MHS to the next level and evaluate great examples like Kaiser Permanente, the Defense Logistics Agency, and most of all the U.S. Special Operations Command. These organizations provide credible insight into what the DoD needs in managing the MHS. All of them have proven what centralized management and decentralized execution provides.

Transforming the MHS must result in the establishment of a JMC that is led by the ASD(HA) and a general officer that provides the command and control. Establishing a JMC also requires incorporating the TRICARE Management Activity (TMA), the TRICARE Regional Offices, and the Service medical assets under the JMC. This does not require additional

allocations, just a realignment of spaces (authorizations). The ASD(HA) should remain under the supervision of the Under Secretary of Defense for Personnel and Readiness and retains his primary role as adviser to the Secretary of Defense on the health of the force, but has increased authority as the civilian leader working closely with a single General Officer instead of relying on the support of the three Surgeons General and eliminate redundancy. A JMC enhances the medical support to its beneficiaries in the 21st Century. The time has come for all of DoD to rely on a newly structured JMC to promote coordinated support to the entire organization.

Endnotes

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